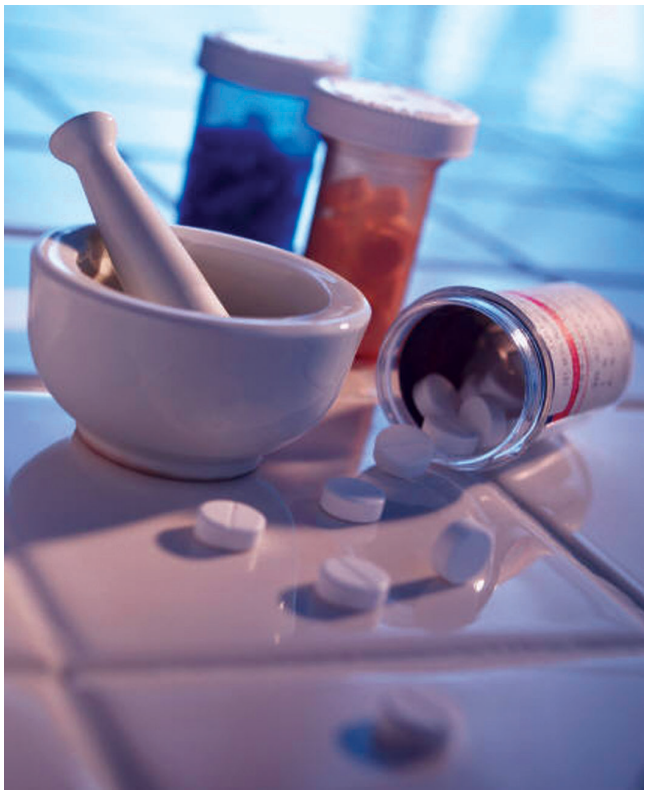
Part 1
Introduction to Medicare

The Medicare Program is currently the world's largest health insurance program. When Medicare began on July 1, 1966, approximately 19 million people enrolled. By 2002, over 41 million people were enrolled in one or both parts of the Medicare Program (known as "Original Medicare"), and 5.5 million of them chose to participate in a Medicare Advantage plan (formerly Medicare + Choice). Medicare also establishes guidelines for private insurance plans (known as Medigap) that help pay for deductibles, coinsurance amounts, and other costs (e.g., prescription drugs) not covered by Medicare. Congress has established specific rules regarding how various beneficiary health insurance plans are coordinated so that Medicare payments are issued fairly and equitably.



In addition to the materials presented in this chapter, the following resources are available to provider staff and beneficiaries who need information regarding Medicare:

Provider Resources:

- Access updated information regarding coverage and payment policy, billing, contacts, and Frequently Asked Questions (FAQs) on the Medicare Learning Network at http://www.cms.hhs.gov/medlearn on the Web.
- Access local policy and claims processing questions from the Medicare payment contractor's website or the toll-free Help Line that was provided during enrollment and is located within the provider newsletter/update.

Beneficiary Resources:

- Access answers to common Medicare questions by calling the toll-free 1-800-MEDICARE (1-800-633-4227) Help Line. TTY users may call 1-877-486-2048.
- Access http://www.medicare.gov on the Web to obtain basic Medicare information and resources such as:
  - Information regarding prescription drugs and other assistance programs;
  - Helpful contacts within the Medicare Program;
  - A dialysis facility comparison tool (to

determine options for saving out-of-pocket expenses);
- A participating physician directory;
- A nursing home comparison tool (to determine options for saving out-of-pocket expenses);
- A supplier directory;
- Publications such as *The Medicare & You 2004* handbook; and
- Beneficiary-focused FAQs.

- Access to a local State Health Insurance Assistance Programs (SHIP) where specially-trained staff and volunteer counselors provide personal health insurance counseling. Services are free, unbiased, and confidential. Local phone numbers are available by calling the toll-free Help Line.

WHAT IS MEDICARE?

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled", is more commonly known as Medicare. As part of the Social Security Amendments of 1965, Medicare legislation established a health insurance program for aged persons to complement the retirement, survivor, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 or over. In 1973, the following groups also became eligible for Medicare benefits:

- Persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months;
- Most persons with end-stage renal disease (ESRD); and
- Certain otherwise non-covered aged persons who elect to pay a premium for Medicare coverage.

Medicare has traditionally consisted of two parts: Part A and Part B (i.e., Original Medicare). A newer, third part of Medicare, sometimes known as Part C, is the Medicare Advantage Program. This program, formerly known as Medicare + Choice, is available to individuals who qualify for Original Medicare. Medicare Advantage was established by the Balanced Budget Act of 1997 (BBA) (Public law 105-33) and expanded beneficiaries' options for participation in private-sector healthcare plans. This drug coverage, known as Medicare Part D, is provided by private health plans. This coverage can be drug-only or is provided through a Medicare Advantage plan that offers comprehensive benefits.

New Medicare Law and Drug Card Information
Current details about the 2003 Medicare legislation and related policies may be found at: http://www.cms.hhs.gov/medicarereform on the Web. If your Medicare patients raise questions about the Discount Drug Card, you should suggest that he or she call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-800-486-2048. The patient could also visit http://www.medicare.gov on the Web and select "Prescription Drug and Other Assistance Programs".

On December 8, 2003, the Medicare Modernization Act (MMA) of 2003 was signed into law. This legislation provides seniors and people living with disabilities with a prescription drug benefit, additional choices, and enhanced benefits under Medicare (including new preventive services under Part B). Most notably, this act provides Medicare beneficiaries with opportunities for discounts on their prescription drugs during 2004 and 2005, as well as voluntary comprehensive Medicare prescription drug coverage, effective on January 1, 2006.

UNDERSTANDING THE MEDICARE PART A BENEFIT

Medicare Part A, referred to as "Hospital Insurance", helps cover services and supplies related to inpatient hospital stays, Skilled Nursing Facility (SNF) care following a related, covered

three-day hospital stay, some home health care, and hospice care for the terminally ill. The Social Security Administration (SSA) will determine if an individual must pay a premium for Medicare Part A, but most beneficiaries do not pay a premium because they (or a spouse) paid Medicare taxes while they were working.

A provider can determine if a beneficiary has Part A benefits by looking at the beneficiary's red, white, and blue Medicare identification card (see Figure 1-1). *Earlier versions of this card may appear differently than the card shown below, however, these earlier versions are still valid.*

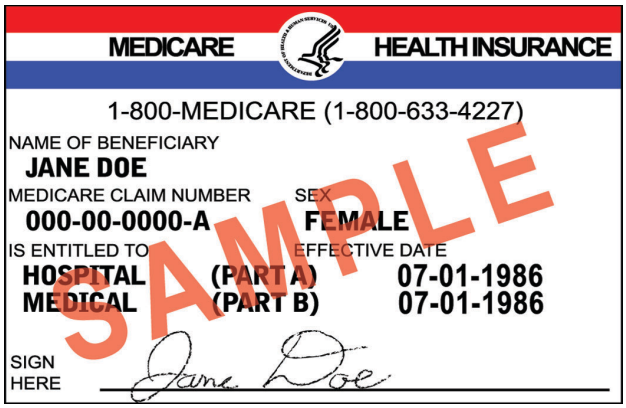
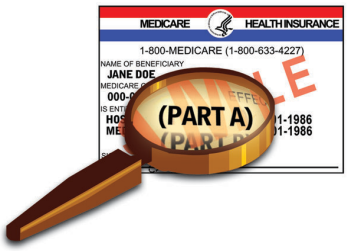


Figure 1-1. Medicare Identification Card

If the beneficiary's Medicare card says "Hospital (Part A)", he or she is entitled to Part A benefits.



If a patient qualifies for inpatient hospital care, services covered by Medicare Part A include the following:

- A semiprivate room;
- Meals;
- Blood transfusions;
- General nursing;
- Medications administered during the inpatient stay;
- Special care units, such as intensive or coronary care; and
- Other hospital services and supplies.

This includes care in critical access hospitals (CAHs) and inpatient mental health care in an independent psychiatric facility. Coverage does **NOT** include private-duty nursing, an in-room television or telephone, or a private room (unless a private room is deemed medically necessary).

If a patient qualifies for SNF care, services covered by Medicare Part A include the following:

- A semiprivate room;
- Meals;
- Blood transfusions;
- Skilled nursing and rehabilitative services;
- Medical social services;
- Medications and medical supplies and equipment used in the facility;
- Ambulance transportation (when other transportation would endanger health) to the nearest provider of needed services not available at the SNF;
- Dietary counseling; and
- Other services that SNFs generally furnish such as laboratory tests and X-rays.

To be eligible for home health care, a beneficiary must meet the following four conditions:

- A doctor must decide that the beneficiary needs medical care in his or her home and must create a plan for home health care for that beneficiary;
- The beneficiary must need at least one of the following:
  - Intermittent (and not full-time) skilled nursing care;
  - Physical therapy;
  - Speech/language therapy services; or
  - Continuing occupational therapy.
- The beneficiary must be homebound (unable to leave home or leaving home is a major effort). If the patient does leave the house, he or she may continue to be considered homebound if the absences are infrequent or for periods of short duration, or are to receive healthcare treatment. This may include regular absences to participate in therapeutic, psychological, or medical

treatment in an adult day-care program that is approved by the state. Any other absence of an individual from the home may be permitted if the absence is infrequent or of short duration; and

- The home health agency (HHA) that provides the care must be Medicare-approved.

Occupational Therapy at Home
Services provided by an occupational therapist (OT) under the home health benefit must be started by another discipline (e.g., intermittent skilled nursing, physical therapy, speech language pathology). Once established, OT becomes a qualifying discipline and may remain in the home as long as OT services are required and the patient meets all the eligibility criteria.

If a beneficiary qualifies for home health care, the following services are covered by Medicare Part A for each 60-day episode of care:

- Part-time skilled nursing care;
- Physical therapy;
- Occupational therapy;
- Speech/language pathology therapy;
- Home health aide services;
- Medical supplies such as wound dressings (but NOT prescription drugs);
- Durable Medical Equipment (DME) such as wheelchairs, hospital beds, oxygen, and walkers; and
- Medical social services.

If a beneficiary qualifies for hospice care, the following services are covered by Medicare Part A in "periods of care" (i.e., two 90-day periods followed by 60-day periods as needed):

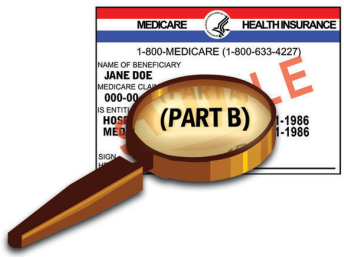
- Doctor services;
- Nursing care;
- Physical therapy;
- Occupational therapy;
- Speech therapy;
- DME;
- Medical supplies such as bandages and catheters;
- Drugs for symptom control and pain relief;
- Short-term hospital and inpatient respite care;
- Home health aide and homemaker services;
- Dietary counseling;
- Counseling to help the beneficiary and their family deal with grief and loss;
- Medical social services; and
- Other services not otherwise covered by Medicare.

Hospice services must be provided by a Medicare-approved hospice, and are usually provided in the patient's home. However, short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest) are covered when needed.

UNDERSTANDING THE MEDICARE PART B BENEFIT

Medicare Part B, referred to as "Medical Insurance", helps cover doctors' services, certain medical items, and outpatient care. Part B also covers medical services such as physical therapy and some home health care furnished by hospitals, SNFs, and other institutional providers, when the beneficiary does not qualify for Part A benefits.

A provider can determine if a beneficiary has Part B benefits by looking at the beneficiary's red, white, and blue Medicare card (see Figure 1-1).



If the beneficiary's Medicare card says "Medical (Part B)", he or she is entitled to Part B benefits.

The following services and supplies are covered under Part B, when medically necessary:

- Medical services;
- Clinical laboratory services;

- Some home health care;
- Outpatient hospital services;
- Blood transfusions (after the first three pints);
- Some preventive services;
- Ambulance services (when other transportation would endanger health); and
- Medical social services.

Part B Coverage and Payment Criteria
Providers who submit Part B claims should always refer to their carrier's Local Medical Review Policies (LMRPs) and other billing guidance for specific coverage and payment criteria.

Part B requires payment of a monthly premium that is usually taken out of the beneficiary's Social Security, Railroad Retirement, or Office of Personnel Management Retirement payment. If the beneficiary does not receive one of these payments, Medicare will bill for the premium every three months. In addition to the premium, the beneficiary must meet an annual deductible and pay all coinsurance amounts unless he or she has other supplemental insurance.

If a beneficiary is entitled to Medicare Part B, covered services for medical care and other services include:

- Doctors' services;
- Outpatient medical and surgical services and supplies;
- Diagnostic examinations and tests;
- Ambulatory surgery center facility fees for approved procedures;
- DME such as wheelchairs, hospital beds, oxygen, and walkers;
- Second surgical opinions;
- Outpatient mental health care; and
- Outpatient physical and occupational therapy, including speech/language therapy.

If a beneficiary is entitled to Medicare, the covered services for clinical laboratory services include the following:

- Blood tests;
- Urinalysis; and
- Other tests requested by a provider.

If a beneficiary is entitled to Medicare, the covered services for home health care include the following:

- Part-time skilled nursing care;
- Physical therapy;
- Occupational therapy;
- Speech/language therapy;
- Home health aide services;
- Medical social services;
- DME such as wheelchairs, hospital beds, oxygen, and walkers; and
- Medical supplies and other services.

Part B helps cover hospital services and supplies that a beneficiary receives as an outpatient when under a doctor's care. Part B also covers blood transfusions that a beneficiary may receive as an outpatient, or as part of a service covered under Part B.

Medicare Part B also helps to cover:

- Ambulance services when other transportation would endanger the patient's health;
- Artificial eyes;
- Artificial limbs that are prosthetic devices, and their replacement parts;
- Braces - arm, leg, back, and neck;
- Chiropractic services (limited), for manipulation of the spine to correct a subluxation;
- Emergency care;
- Eyeglasses - one pair of standard frames after each cataract surgery with an intraocular lens;
- Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to Medicare Part A coverage, in a Medicare-certified facility;
- Kidney dialysis;
- Medical Nutrition Therapy (MNT) services for people who have diabetes or kidney

disease (unless currently on dialysis) with a doctor's referral. The MNT services will be covered for three years after the kidney transplant;
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies;
- Very limited outpatient prescription drugs (e.g., some oral drugs for cancer);
- Preventive services:
  - Bone mass measurements;
  - Colorectal cancer screening by colonoscopy;
  - Diabetes services and supplies;
  - Glaucoma screening;
  - Mammography screening;
  - Papanicolaou (Pap) test and pelvic examination (includes a clinical breast exam);
  - Prostate cancer screening by digital rectal examination (DRE); and
  - Shots (vaccinations).
- Prosthetic devices, including breast prosthesis after mastectomy;
- Second surgical opinion by a doctor (in some cases);
- Services of practitioners such as clinical social workers, physician assistants (PAs), and nurse practitioners;
- Telemedicine services in some rural areas;
- Therapeutic shoes for people with diabetes (in some cases);
- Transplants - heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions and when performed at Medicare-certified facilities); and
- X-rays, MRIs, CT scans, EKGs, and some other purchased diagnostic tests.

UNDERSTANDING THE MEDICARE ADVANTAGE (FORMERLY MEDICARE + CHOICE) PLAN

The Medicare Advantage Program was established by the Balanced Budget Act of 1997 (BBA). The program is a set of healthcare options created by the BBA to provide care under contract to Medicare, to possibly reduce beneficiaries' out-of-pocket expenses, and offer beneficiaries more health care and contractor choices. Beneficiaries who qualify for Original Medicare benefits (Part A and Part B) have the option to be covered under a Medicare Advantage plan if one is available in their area instead of Original Medicare.

Medicare Advantage
Since MMA was signed into law in 2003, the Medicare Advantage program will undergo some significant changes. Effective March 1, 2004, increased payments will go into effect to Medicare Advantage (formerly Medicare + Choice). Additional information regarding MMA is available at http://www.medicare.gov/medicarereform/ on the Web. The new 2004 Medicare Advantage payment rates are available at http://www.cms.hhs.gov/healthplans/rates/ on the Web.

To participate in Medicare, a Medicare Advantage plan must have a contract with the Secretary of The Department of Health and Human Services (DHHS). It must provide the same services a beneficiary would be eligible to receive from Medicare if he or she were in Original Medicare. In other words, the beneficiary is still technically "on Medicare", but has selected a different contractor and is required to receive services according to that contractor's arrangements.

Medicare Advantage plans may include the following:

- Medicare managed care plan;
- Medicare managed care plan with a Point of Service (POS) option;
- Provider Sponsored Organization (PSO);
- Preferred Provider Organization (PPO);
- Medical Savings Account (MSA);
- Private fee-for-service plan; or
- Religious fraternal benefit society plan.

The Medicare Advantage Program places special limitations and requirements on beneficiaries with

ESRD. Persons entitled to Medicare because they have ESRD are limited to the Original Medicare Plan, except in special circumstances. A beneficiary with ESRD cannot join a Medicare Advantage plan; however, if he or she developed ESRD while previously enrolled, he or she can remain enrolled. He or she may also join a different plan offered by the same company in the same state.

If a beneficiary who has ESRD is enrolled in a Medicare Advantage plan and the plan stops offering service in the beneficiary's service area, he or she may join another Medicare Advantage plan if one is available. This regulation applies to anyone whose plan left the Medicare Advantage plan after December 31, 1998.

If a beneficiary leaves a Medicare Advantage plan for other reasons after developing ESRD, he or she can only choose the Original Medicare Plan.

Persons who have had a successful kidney transplant and no longer require regular dialysis are not considered to have ESRD. This means that the beneficiary is eligible to join a Medicare Advantage plan as long as he or she has met all other eligibility requirements.

PROVIDING SERVICES TO PATIENTS ENROLLED IN MEDICARE ADVANTAGE PLANS

Physicians and suppliers and their billing personnel must be aware that Medicare Advantage plans do not operate under the same coverage and payment policy for claims processing as Original Medicare. ***If a beneficiary is a member of a Medicare Advantage plan, the local Part B carrier cannot process claims for that beneficiary.***

When a physician or supplier submits claims for a beneficiary enrolled in a Medicare Advantage plan, the local Medicare Part B carrier will deny payment (except dialysis and related services provided in a dialysis facility). After denial, the carrier will automatically transfer the claim to the appropriate Medicare Advantage plan.

However, a Medicare managed care plan is **NOT** responsible for paying Medicare Advantage claims, **EXCEPT** under the following situations:

- The physician or supplier is affiliated with the Medicare Advantage plan; or
- The physician or supplier furnishes emergency services, urgently needed services, or other covered services not reasonably available through the Medicare Advantage plan.

FILING CLAIMS WITH A MEDICARE ADVANTAGE PLAN

A provider may be reimbursed when filing a claim to a Medicare Advantage plan if they are an in-network provider, or an out-of-network provider that furnished services that are identified in the second bullet of Part I, Providing Services to Patients Enrolled in Medicare Advantage Plans. However, if the plan denies the claim, the provider has the right to appeal the claim to the plan or CMS. An out-of-plan provider may also collect the full fee for services rendered from the patient if the patient did not receive prior authorization to see the out-of-plan provider.

PROVIDERS WHO ARE NOT MEDICARE ADVANTAGE PROVIDERS

BEFORE rendering service, providers who are affiliated with a Medicare Advantage plan should emphasize to their patient what their financial liability will be if the patient did not receive prior authorization to see the out-of-plan provider. If the patient chooses to see a provider not affiliated with their Medicare Advantage plan for healthcare services, he or she should clearly understand that he or she may be responsible for the full fee for services rendered.

WHAT IS MEDICAID?

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in

1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest individuals. Within broad national guidelines established by Federal statutes, regulations, and policies, each state:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and/or services within a state can change during the year.

THE MEDICARE-MEDICAID RELATIONSHIP

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid Program. For persons who are eligible for full Medicaid coverage, the Medicare healthcare coverage is supplemented by services that are available under their state's Medicaid Program, according to eligibility category. These additional services may include nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. **For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare Program before any payments are made by the Medicaid Program, since Medicaid is always the "payer of last resort".**

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid Program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the two best-known and largest categories of these types of beneficiaries. For QMBs, Medicaid pays the Medicare Part A and Medicare Part B premiums and the Medicare coinsurance amounts and deductibles, subject to limits that states may impose on payment rates. For SLMBs, the Medicaid Program pays only the Medicare Part B premiums.

A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Medicare Part B coverage. If these persons meet certain requirements, they may qualify to have Medicaid

pay their Medicare Part A premiums as Qualified Disabled and Working Individuals (QDWIs). According to CMS estimates, Medicaid currently provides some level of supplemental health coverage for 5 million Medicare beneficiaries within the above three categories.

States vary in their participation in these programs for people with limited income and resources that help pay Medicare premiums. Some programs also pay Medicare deductibles and coinsurance.

Availablity of "Medicare Savings" Programs
Providers may recommend that low-income patients call 1-800-MEDICARE (1-800-633-4227) to see if such "Medicare Savings" programs are available locally. TTY users should call 1-877-486-2048.

HOW IS MEDICARE ADMINISTERED?

As a Federal health insurance benefit program, Medicare represents the cooperative efforts and organization of numerous government and non-governmental organizations. The following section identifies the major organizations that impact Medicare.

CONGRESS

Congress passes laws that affect Medicare reimbursement of providers and beneficiaries.

SOCIAL SECURITY ADMINISTRATION (SSA)

The SSA, an independent agency, has special responsibilities in five major benefit areas: retirement, disability, family benefits, survivors, and Medicare. The SSA assures that beneficiaries are eligible for Medicare benefits and enrolls them in Parts A and/or B, the Federal Black Lung Program (also referred to as the Funds), or Medicare Advantage (formerly Medicare + Choice). When a patient enrolls in Medicare, CMS issues an initial enrollment package and a Medicare identification card.

The SSA is also responsible for the following:

- Maintaining deductible status;
- Requesting replacements for lost or stolen Medicare cards;
- Updating address changes;
- Maintaining and establishing beneficiary enrollment;
- Collecting premiums from beneficiaries who receive retirement or disability benefits; and
- Educating beneficiaries regarding coverage and insurance choices.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

DHHS is the U.S. Cabinet-level department that oversees Federal health programs, including Medicare, and provides essential human services. The Secretary of DHHS contracts with private insurance companies to process Medicare claims. DHHS is responsible for conducting fraud and abuse audits and investigations for the Federal Government.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CMS, an agency of DHHS, administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) by creating coverage and payment policies according to Congressional mandates. CMS also regulates laboratory testing and the survey and certification of healthcare facilities, including nursing homes, home health agencies, intermediate care facilities for the mentally handicapped, and hospitals.

WHERE IS CMS LOCATED?

The CMS Central Office is located in Baltimore, Maryland. The following ten Regional Offices (ROs), shown with their associated region codes, provide policy guidance to several Medicare payment contractors:

- Atlanta [04];
- Boston [01];
- Chicago [05];
- Dallas [06];
- Denver [08];
- Kansas City [07];
- New York [02];
- Philadelphia [03];
- San Francisco [09]; and
- Seattle [10].

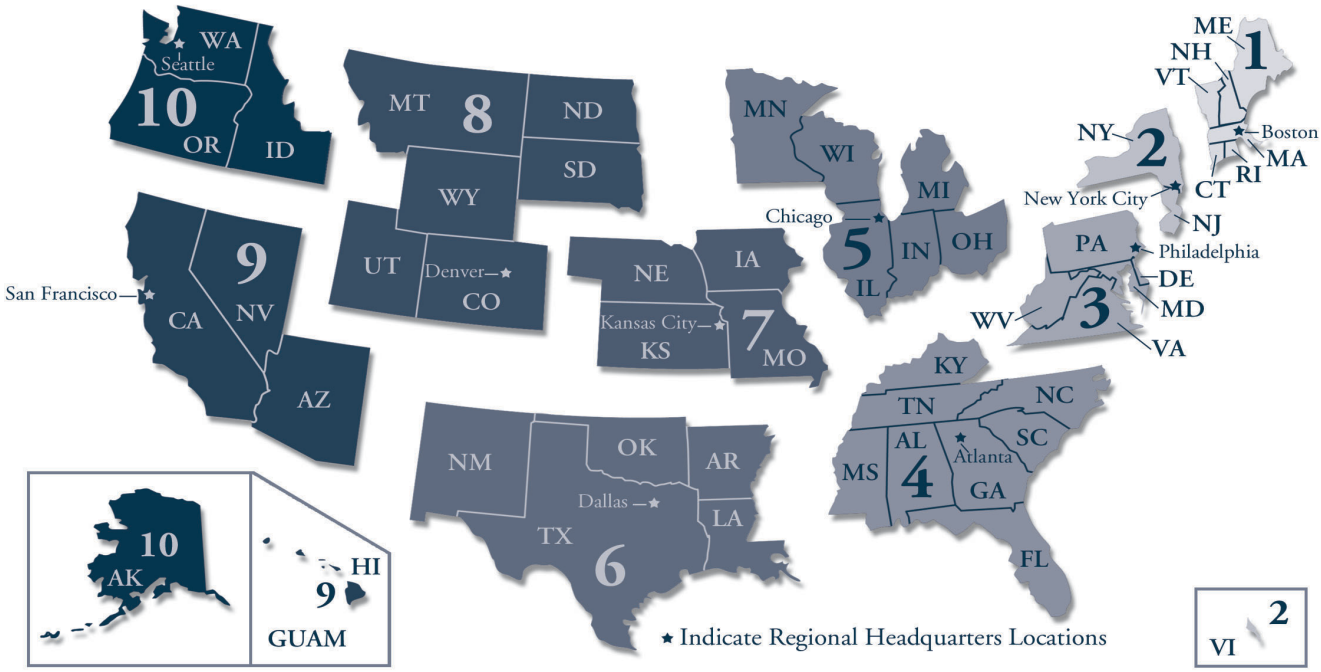
Figure 1-2 shows how each CMS region is defined by state and/or territory.

WHAT ARE FISCAL INTERMEDIARIES (FIs) AND CARRIERS?

Medicare's Part A and Part B fee-for-service claims are processed by non-governmental organizations or agencies that contract to serve as the fiscal agent between providers and suppliers and the Federal Government. These claims processors are known as *FIs* and *carriers*. These contractors apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare FIs process Part A claims for institutional services, including inpatient hospital claims, SNFs, Home Health Agencies (HHAs), and hospice services. FIs also process Part B claims submitted by institutional providers, including hospital outpatient services. Examples of FIs include the Blue Cross Blue Shield Association (BCBSA), which utilizes its plans in various states, and other commercial insurance companies. An FI's responsibilities include the following:

Figure 1-2. Map of Regions by State and/or Territory



RO Contact Information
To access contact information for each RO, please visit the CMS ROs at http://www.cms.hhs.gov/about/regions/professionals.asp on the Web.

- Determining costs and reimbursement amounts;
- Maintaining records;
- Establishing controls;
- Safeguarding against fraud and abuse or excess use;
- Conducting reviews and audits;
- Making payments to providers for services; and
- Assisting both providers and beneficiaries as needed.

Medicare carriers handle Part B claims for services by physicians and medical suppliers. Examples of carriers are the BCBSA plans in a state, and various commercial insurance companies. Carriers' responsibilities include the following:

- Determining charges allowed by Medicare;
- Maintaining quality-of-performance records;
- Assisting in fraud and abuse investigations;
- Assisting physicians, suppliers, and beneficiaries as needed; and
- Making payments to physicians and suppliers for services that are covered under the Part B benefit.

Physicians and suppliers that have claims processed by carriers are considered Part B providers. Carriers may only process Part B claims. Conversely, institutional providers that have claims processed by FIs are considered Part A providers. This situation sometimes creates confusion since FIs process Medicare claims for both Part A and Part B benefits. When a provider is called a Part A provider, it simply means that the provider has claims processed by an FI. For example, an outpatient rehabilitation facility (commonly known as a rehabilitation agency) can only bill for Part B services, but since it submits claims to an FI, it is considered a Part A provider.

Submitting Claims to FIs
Providers who submit claims to FIs should always refer to their FI's Local Medical Review Policies (LMRPs) and other billing guidance for specific coverage and payment criteria.

Part B providers (physicians and suppliers) can only bill for services under the Part B benefit (see Figure 1-3). Part A providers can bill for services under the Part A benefit, the Part B benefit, or both.

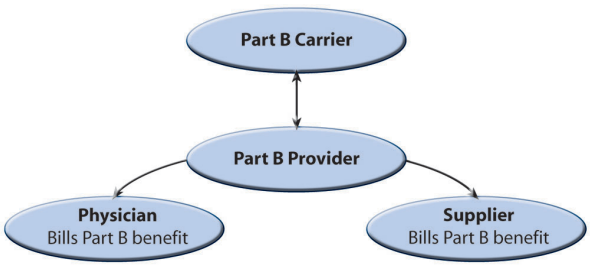


Figure 1-3. Part B Benefit

WHO ARE MEDICARE BENEFICIARIES?

Medicare Part A eligibility is based on one's earnings, or on the earnings of a spouse, parent, or child. A specified number of "quarters of coverage" (QCs) must be earned through payment of payroll taxes. The exact number of QCs required for insured status depends on the basic group to which the individual belongs. If an individual has paid taxes for 40 QCs, he or she is

Directory of FIs and Carriers
To view a current directory of FIs and carriers, please visit the Intermediary-Carrier Directory at http://www.cms.hhs.gov/contacts/incardir.asp on the Web.

eligible for "premium-free" Part A. Those who work for shorter periods would need to pay premiums depending on the length of taxpaying employment.

The three basic types of individuals eligible for Medicare insurance include:

- The aged;
- The disabled; and
- Those with ESRD.

Medicare Part B is a voluntary program for which the insured pays a monthly premium. All individuals who are entitled to premium-free Part A are eligible to enroll in Part B. Individuals who are not eligible for premium-free Part A can enroll in Part B if they are:

- Age 65;
- A resident of the U.S.; and
- A U.S. citizen or an alien lawfully admitted for permanent residence who has continuously resided in the U.S. for the five-year period immediately preceding the month he or she files for Part B.

The cost of this premium is normally deducted from Social Security checks automatically and represents 25% of the cost of coverage. The remainder is financed from general tax revenues.

As described earlier, an individual eligible for Original Medicare (Part A and Part B) has the option to enroll in a Medicare Advantage plan at any time. Since the enrollee has options to enroll in Part B or Medicare Advantage at different times than when he or she enrolled in Part A, the effective dates on his or her Medicare cards may vary, depending on the month/year in which enrollment takes place.

As described in Part I, The Medicare-Medicaid Relationship, certain low-income individuals may also qualify through Medicare Savings Programs. Many states have such programs for people with limited income and resources that pay Medicare premiums when individuals do not qualify for Medicaid. Some programs may also pay Medicare deductibles and coinsurance amounts.

The following section details the minimum criteria people must meet to enroll in the Medicare Program as an aged insured, disabled insured, or ESRD insured beneficiary.

AGED INSURED

An "aged insured" person is age 65 years old or older and eligible for monthly Social Security or Railroad Retirement cash benefits, or equivalent Federal benefits. Medicare enrollment typically occurs simultaneously upon application for Social Security benefits. Therefore individuals that receive SSA benefits "early" will be automatically enrolled in Medicare Part A the month they turn age 65.

Medicare Eligibilty and Enrollment Information
Questions about Medicare eligibility and enrollment should be referred to the beneficiary's local Social Security Field Office or the SSA's toll-free number at 1-800-772-1213. TTY users should call 1-800-325-0778.

Medicare Part B is voluntary and becomes effective based on the enrollment period in which the individual enrolls. The earliest an individual may enroll in Part B is three months before a person turns age 65 and ends three months later. If a beneficiary chooses *not* to enroll in Medicare Part B during the initial enrollment period, he or she may enroll during other specified times. However, the cost of Part B may go up 10% for each 12-month period the beneficiary was eligible for Part B, except in special cases. The beneficiary will have to pay this extra amount for the rest of his or her life.

DISABLED INSURED

An insured person entitled to Social Security, Railroad Retirement, or equivalent Federal benefits, based on disability, is automatically entitled to Part A hospital insurance and is

considered enrolled for Part B unless coverage was refused. This type of entitlement is also available to a disabled widow or widower, or the disabled child of a deceased, disabled, or retired worker. Generally, entitlement begins after the individual has been entitled to receive benefits for 24 months, not the date he or she became disabled. However, individuals whose disability is Amyotrophic Lateral Sclerosis (ALS) do not have to wait 24 months for Medicare. These beneficiaries are entitled to Medicare the first month they are entitled to disability benefits.

If it is determined that an individual is no longer disabled, a notification of disability termination is sent, and Medicare Part A and Part B entitlement ends the following month.

END-STAGE RENAL DISEASE (ESRD) INSURED

Individuals of any age who require regular dialysis or a kidney transplant are eligible for Medicare if they:

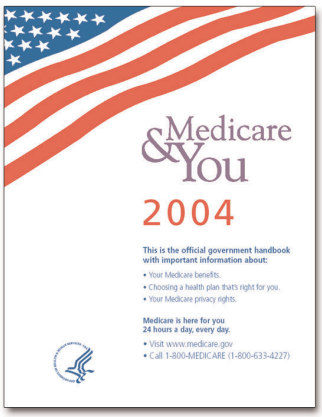
- Worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee; or
- Are receiving, or are eligible to receive, Social Security or Railroad Retirement benefits; or
- Are the spouses or dependent children of such insured or entitled persons.

Entitlement to Medicare usually begins after a three-month waiting period (e.g., the first day of the third month after the course of renal dialysis begins). Entitlement can begin at an earlier date, if certain requirements are met.
Medicare is the secondary payer for claims during the 30-month coordination period for ESRD beneficiaries who are covered by a Group Health Plan (GHP). This 30-month coordination period begins with the first day of Medicare eligibility. The exception is an aged or disabled beneficiary who had GHP coverage that was secondary to Medicare when ESRD occurred.

For patients eligible for Medicare solely based on ESRD, coverage ends on the earliest of the following dates:

- The patient's date of death;
- The last day of the 12th month after the month the course of dialysis is discontinued, unless the patient receives a kidney transplant during that period or begins another course of dialysis; or
- The last day of the 36th month after a person receives a kidney transplant. If the transplant fails and a regular course of dialysis is initiated or another transplant is performed within the 36 months, entitlement continues. If a patient whose entitlement based on ESRD has ended begins a new course of dialysis or has a kidney transplant, re-entitlement begins without a waiting period.

WHAT ARE MEDICARE BENEFICIARY RIGHTS?



Provider staff should be familiar with the Medicare beneficiary rights that apply to the type of services they furnish and the type of Medicare insurance plan for which they are submitting claims. The Medicare beneficiary handbook, *Medicare & You 2004*, is published by CMS and sent to all Medicare beneficiaries. The handbook discusses the guaranteed rights of Medicare beneficiaries, which include the following:

- Protection when they get healthcare services;
- Assured access to needed healthcare services;
- Protection against unethical practices;
- The right to receive emergency care without prior approval;

- The right to appeal the Original Medicare Plan's decision about payment/services provided;
- The right to information about all treatment options;
- The right to know how their Medicare health plan pays its doctors; and
- The right of the beneficiary to submit a written request to a physician or supplier for an itemized statement for any Medicare item or service received. The physician or supplier must furnish the itemized statement within 30 days of the request. Failure to provide the statement on time can result in a civil monetary penalty of up to $100.00 for each failure.

CMS has also developed an additional publication, *Your Medicare Rights and Protections*, that provides details about beneficiary rights that are specific to Original Medicare, Medicare Managed Care Plans, and Medicare Private Fee-for-Service Plans.

Beneficiary Rights Information
To view publications and many other helpful documents regarding beneficiary rights, please visit http://www.medicare.gov on the Web.

HOW DOES A PROVIDER IDENTIFY A QUALIFIED MEDICARE BENEFICIARY?

When an individual becomes entitled to Medicare, he or she receives a health insurance card. This card contains important information that must be included on all claims submitted by providers:

- Name;
- Sex;
- Health Insurance Claim Number (HICN);
- Effective date of entitlement to Part A insurance; and
- Effective date of entitlement to Part B insurance.

Most Medicare beneficiaries receive health insurance cards issued by the SSA; however, the RRB issues a Medicare card to individuals eligible for Medicare Railroad Retirement benefits.

Billing Without a Medicare Card
Providers may bill Medicare without a copy of the patient's Medicare card but they should confirm that the patient has coverage prior to billing.

CMS-ISSUED MEDICARE NUMBERS

Medicare numbers issued by CMS typically reflect the Social Security Number (SSN) of either the insured or a spouse (possible divorced or deceased) depending on the wage earner upon whose earnings eligibility is based.

RRB-ISSUED MEDICARE NUMBERS

Medicare numbers issued by the RRB may be the insured's SSN or a six-digit number (zeros may be added at the beginning to bring it to nine digits). Regardless of the length of the number, the insured's number will always have an alpha *prefix* (with one or more characters). For example, H000-000 or H000-000-000 would be a railroad pensioner (age or disability).

Accuracy of Beneficiary Information is Important
*Failure to record the beneficiary's name and identification number on a claim **exactly** as they appear on the Medicare card may result in a payment denial or claim delay.*

Patient Identification
Due to an increase in lost and stolen Medicare cards, checking and copying a patient's picture identification is suggested to ensure that the patient is eligible to receive benefits. *If Medicare has paid a claim for services rendered to a non-Medicare-eligible beneficiary, a refund request may be generated.*

VERIFYING BENEFICIARY ELIGIBILITY

Social Security benefits are the basis for eligibility for most Medicare patients. The eligibility source can be determined by asking to see the patient's Medicare card. Maintaining a photocopy of the card in the patient's file may prevent errors. The provider's office should develop a process to regularly verify Medicare insurance information and update patients' records to reflect current information.

WHAT IS MEDIGAP?

A Medigap policy is a health insurance policy sold by private insurance companies to fill “gaps” in the Original Medicare Plan coverage. Medigap policies must follow Federal and State laws that protect the beneficiary. The front of the Medigap policy must clearly identify it as “Medicare Supplemental Insurance”. In all states except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of ten standardized policies that can be compared easily. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy may be sold as a “Medicare SELECT” policy.

Updated MMA Information
Updated information may be obtained using the Medicare Personal Plan Finder Tool available at http://www.medicare.gov/Help/mppf.asp on the Web.

Medicare SELECT policies usually cost less because the beneficiary must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from the policy. In an emergency, patients may use any doctor or hospital. Certain changes to Medigap policies will occur with the implementation of the MMA.

HOW DO THE COORDINATION OF BENEFITS (COB) AND MEDICARE SECONDARY PAYER (MSP) PROGRAMS WORK?

The MSP Program precludes Medicare from making primary claims payment when a beneficiary has other insurance that should pay first. For example, if a Medicare beneficiary is covered by a GHP as a result of his or her own or his or her spouses' current employment, charges for medical services must first be submitted to his or her GHP for payment.

MSP REGULATIONS

Until 1980, the Medicare Program was the primary payer in all situations except those involving Workers' Compensation (WC) (including the Federal Federal Black Lung Program) benefits. Since 1980, changes in the Medicare law have resulted in Medicare being the secondary payer in other situations. The MSP Program protects Medicare funds and ensures that Medicare does not pay for services reimbursable under private insurance plans or other government programs. Medicare may not

pay if payment has been made, or can be reasonably expected to be made, with respect to an item or service that is covered under other health insurance or coverage.

MEDICARE COORDINATION OF BENEFITS (COB)

The purpose of the COB Program is to identify healthcare coverage that beneficiaries may have that pays primary to Medicare and to coordinate the payment process to prevent mistaken Medicare primary payments. CMS awarded a contract in November 1999, referred to as the Medicare COB contract, to consolidate activities that support the collection, management, and reporting of other insurance coverage that Medicare beneficiaries have. This is one of many initiatives under the Medicare Integrity Program designed to further expand CMS' campaign against Medicare waste, fraud, and abuse. Please see Part 3, Submitting Medicare Secondary Payer (MSP) Claims, for more information regarding submission of MSP claims.